

# DURABLE MEDICAL EQUIPMENT PAYMENT SYSTEM

payment**basics**

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Medical equipment needed at home to treat a beneficiary's illness or injury is covered under the durable medical equipment (DME) benefit. Medicare spent about \$7.0 billion on DME in calendar year 2018, substantially below Medicare's peak DME spending of \$8.7 billion in 2008.<sup>1</sup>

DME is defined as equipment that:

- can withstand repeated use,
- primarily and customarily serves a medical purpose,
- generally is not useful to a person without an illness or injury, and
- is appropriate for use in the home.

Medicare Part B covers medically necessary DME prescribed by a clinician. Some examples of DME covered by Medicare include walkers, wheelchairs, and home oxygen equipment and related supplies. Medicare also covers supplies that are necessary for the effective use of DME (e.g., oxygen in oxygen tanks).

Medicare does not cover DME that is unsuitable for use in the home (such as equipment used in hospitals or skilled nursing facilities) or that is intended to help outside the home (such as a motorized scooter for getting around outside the home). In addition, most items that are generally for convenience or comfort (such as grab bars) or disposable supplies not used with DME (such as incontinence pads) are not covered.

## DME fee schedule

For items not subject to competitive bidding, Medicare pays for DME using a fee schedule. Fee schedule rates are largely based on supplier charges from July 1986 through June 1987 (updated for inflation) and on information such as unadjusted list prices for products introduced after this time period.

Medicare payment is equal to 80 percent of the lower of either the actual charge for

the item or the fee schedule amount for the item. The beneficiary is responsible for 20 percent coinsurance.

CMS calculates the DME fee schedule amounts for the following DME payment categories.

- *Inexpensive and other routinely purchased items:* These items have a purchase price of \$150 or less; are generally purchased (as opposed to rented) 75 percent of the time or more; or are accessories used in conjunction with certain nebulizers, aspirators, and ventilators. If covered, these items can be purchased new or used. They can also be rented, but total payment amounts cannot exceed the purchase-new amount for the item.
- *Frequently serviced items:* If covered, these items can be rented as long as they are medically necessary.
- *Oxygen and oxygen equipment:* One bundled monthly payment amount is made for all covered equipment, oxygen, and accessories. Medicare payment for oxygen equipment may not continue beyond 36 months of continuous use. After the 36-month rental cap, Medicare will continue to pay for oxygen and maintenance but not the equipment itself.
- *Other covered items that are necessary for the effective use of DME:* If covered, Medicare pays for the purchase of these supplies.
- *Capped rental items:* These items are not covered in any other DME category and are generally expensive items that have historically been rented. If covered, Medicare generally pays for the rental of these items for a period of continuous use not exceeding 13 months. The fee schedule amount is based on the base year purchase price and varies by rental month.

Fee schedule amounts are not calculated for certain customized items. If covered,

*This document does not  
reflect proposed legislation  
or regulatory actions.*

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Medicare pays a lump-sum amount for the purchase of the item, as determined by the Medicare Administrative Contractor.

### **Competitive bidding**

Competitive bidding in Medicare for DME items was first tested in a demonstration program in two areas from 1999 to 2002. In that demonstration, competitive bidding lowered Medicare payments for selected items by 19 percent overall. Analyses of the demonstration also found that beneficiary access and quality of service were essentially unchanged.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated that the competitive bidding program (CBP) for DME, prosthetics, orthotics, and related supplies be phased in, starting with 10 metropolitan statistical areas (MSAs) in 2008. The first round of competitions took place, and contracts were awarded in 10 product categories, effective July 1, 2008. However, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) terminated the contracts awarded in the first round and required CMS to rebid the competition. To offset the cost of delaying the program, the fee schedule amounts for selected items were reduced by 9.5 percent nationwide in 2009.

In 2011, CMS rebid the canceled round; that round was known as “Round 1 rebid” (Figure 1). CMS has conducted two additional rounds of competitions (i.e., “recompetes”) in the same Round 1 areas. These rounds are referred to as “Round 1 recompetete” and “Round 1 2017.” CMS also conducted competitions in additional areas beginning in July 2013, referred to as “Round 2” and “Round 2 recompetete.” Finally, CMS implemented the National Mail-Order Program for diabetes testing supplies in July 2013. As the name implies, this competition covers the entire country, including both urban and rural areas, but applies only to diabetes testing supplies purchased on a mail-order basis.

All rounds of the CBP expired on December 31, 2018. In 2019 and 2020, there will be a temporary gap period

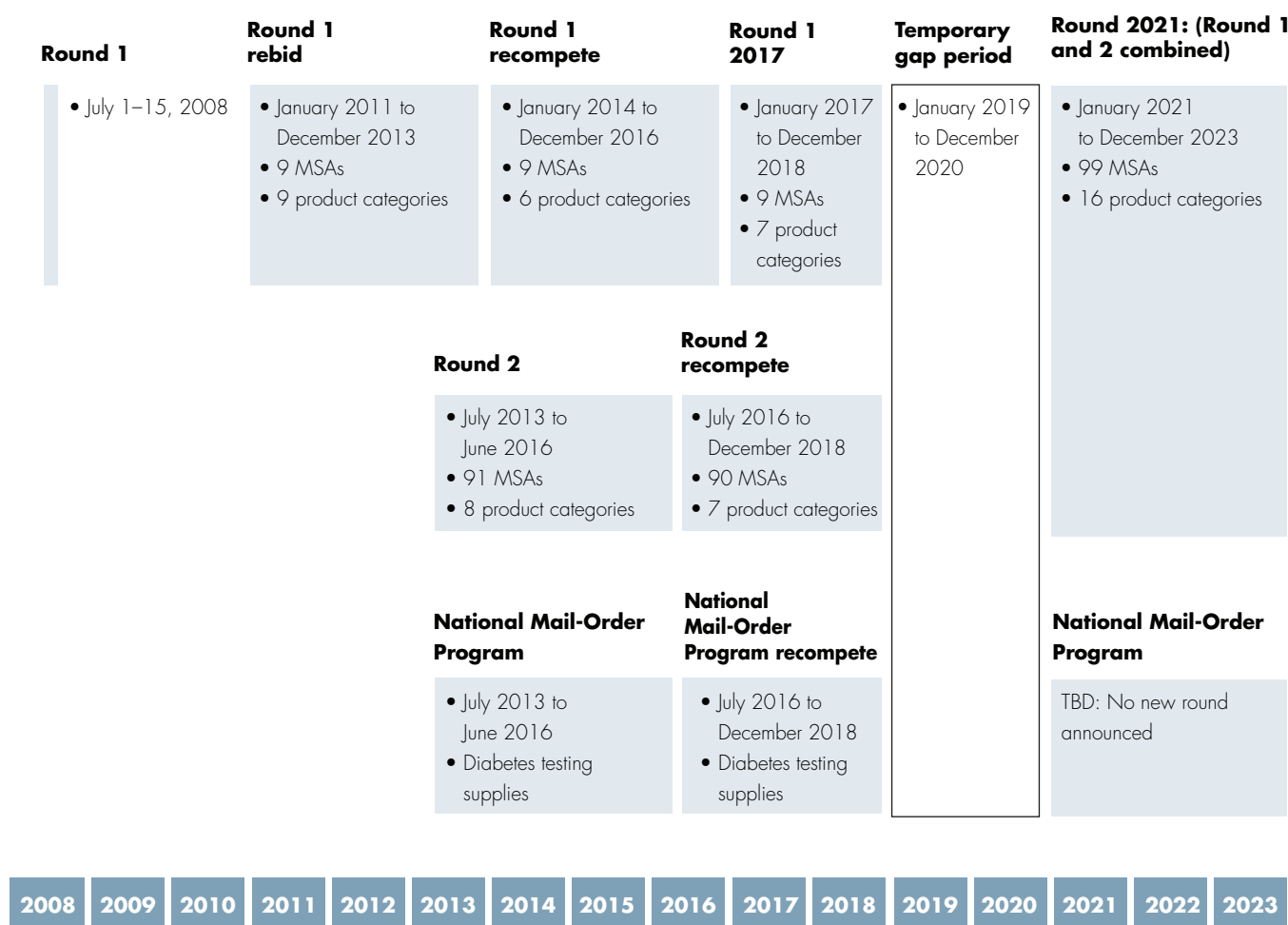
during which CMS will allow any willing supplier to furnish DMEPOS products on a fee schedule basis. For products formerly included in the CBP, payment rates will be based on CBP rates, updated for inflation. In 2021, CMS has proposed combining Rounds 1 and 2 into one round referred to as “Round 2021.” However, to date, CMS has not proposed a new round for the National Mail-Order Program for diabetes testing supplies.

Under the CBP, suppliers operating in a competitive bidding area (CBA) submit a bid for selected products. Bids are evaluated based on the supplier’s eligibility, financial stability, and bid price. Contracts are awarded to the suppliers who offer the best price and meet applicable quality and financial standards. For each item, the payment amount—referred to as the single payment amount (SPA)—is derived from the maximum of all winning bids for the item.<sup>2</sup> Suppliers awarded contracts (i.e., contract suppliers) must agree to accept assignment on all claims for bid items and be paid the SPA.

CMS also uses pricing information from the CBP to adjust fee schedule payment rates for areas and settings not directly covered by the CBP. Beginning July 2013, CMS sets the payment rates for non-mail-order diabetes testing supplies equal to the payment rates determined through the National Mail-Order Program. For products other than diabetes testing supplies, CMS began in 2016 adjusting fee schedule payment rates in non-CBAs (i.e., small/moderate sized urban areas and rural areas) using information from the CBP. In 2016, Medicare paid a 50/50 blend of historical fee schedule rates and rates derived from the CBP. From January 2017 through May 2018, Medicare paid rates that were 100 percent derived from the CBP. Beginning June 2018, Medicare reverted to a 50/50 blend for rural and non-contiguous non-CBAs, while continuing to pay rates that are 100 percent derived from the CBP in urban, contiguous non-CBAs.

The CBP has driven down the cost of DME for Medicare and beneficiaries. Compared

**Figure 1 Timeline of DMEPOS competitive bidding program rounds, 2008–2023**



Note: DMEPOS (durable medical equipment, prosthetics, orthotics, and supplies), MSA (metropolitan statistical area). Round 2 recompetes covers the same geographic areas that were included in Round 2. However, as a result of the Office of Management and Budget's updates to the original 91 Round 2 MSAs, there are 90 MSAs for Round 2 recompetes. The specific DMEPOS items included in a product category may change between rounds.

Source: Government Accountability Office and CMS.

with payment rates in the year before competitive bidding, Medicare's payment rates for some of the highest expenditure DME products have fallen by an average of nearly 50 percent. In 2012, CMS estimated that competitive bidding would save more than \$42 billion over 10 years—\$25 billion in savings for the program and \$17 billion in savings for beneficiaries. ■

- 1 These numbers include payments for DME, prosthetics, orthotics and supplies, a category to which DME belongs under Medicare.
- 2 Prior to Round 2021, SPAs were set using the median (instead of the maximum) of all winning bids for an item. CMS finalized this and other changes to the CBP in a November 2018 final rule (83 FR 56922).

